STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005002	A. BUILDING: _____ B. WING _____	04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOSPITALS INC	600 GRANT ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was an investigation of two State hospital complaints. Complaint: #IN00130848 Unsubstantiated: Lack of sufficient evidence. #IN00132712 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005002 Survey Date: 04/09/2014 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Methodist Hospitals is in compliance with 410 IAC 15-1.5-2, Infection control, 410 IAC 15-1.5-4, Medical records, 410 IAC 15-1.5-5, Physician services, 410 IAC 15-1.5-6, Nursing services, 410 IAC 15-1.5-8, Physical plant, maintenance and environmental services and 410 IAC 15-1.6.2, Emergency services, Hospital Licensure Rules. QA: claughlin 04/15/14	S 000		